

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-008183

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 314 Primary Registration District No. 4437 Registrar's No. 6

FILED FEB 28 1963

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Louisy City</u>		c. CITY OR TOWN <u>Louisy City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>Louisy City</u>		d. STREET ADDRESS (If outside, give location) <u>Louisy City</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOSIE</u> Middle <u>LANGFORD</u> Last <u>LANGFORD</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (last birthday) <u>84</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u>
13a. FATHER'S NAME <u>Matthew Long</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Lane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		14. NAME OF HUSBAND OR WIFE <u>J M Langford (Deceased)</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thromboses</u>		INTERVAL BETWEEN ONSET AND DEATH. <u>1 MO</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY: Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY <u>St. Clair</u> STATE <u>MO</u>
21. I attended the deceased from <u>July 54</u> to <u>12 Feb 63</u> and last saw her alive on <u>11 Feb 63</u> Death occurred at <u>10 -</u> A_m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Oscoda Mo</u>	22c. DATE SIGNED <u>2-11-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2-15-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>	23d. LOCATION (City, town, or county) (State) <u>St. Clair county MO.</u>
24. FUNERAL DIRECTOR <u>F. L. SCHABERG</u> ADDRESS <u>CLINTON, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>2-11-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

DATE AMENDED

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ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DEC 24 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. R. Kenney

Licensed Embalmer No. 3099

P. O. Address Clinton Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.